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ABSTRACT

The American Medical Association and the American Library Association are comparatively studied in this essay which emphasizes organizational structure. The chief characteristics of professional associations are briefly reviewed and the three primary problem areas relating to organizational structure--participation of the membership, role of the leadership, and segmentation of the profession--are closely examined. The historical development of the associations' organizational structures is traced and their current structures are described in some detail. Several selective features of the two associations which give insight into their operation are analyzed and the responses to the three problem areas are discussed. The study results indicate the following: American Medical Association has been a medium through which the goals of the profession have been voiced. These goals have shaped the organizational structure which has enabled the profession to deal successfully with the three problem areas discussed. On the other hand, the American Library Association has not focused on clearly defined goals and the organizational structure has not encouraged concerted action toward professional objectives. The three problems areas have been met with varying success. (Author/NH)

THE AMERICAN MEDICAL ASSOCIATION AND THE AMERICAN LIBRARY ASSOCIATION

A Study of Developing Organizational Structure

by

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The study of professions has absorbed the interest of social scientists for a long time. Some of the research has focused on the behavior of professionals in an institutional framework; other work has been done on such areas as the relationship of the professional to his superiors, his peers, and his clientele. There remains a need for study of the behavior of professionals in their occupational associations.[1] The se ral works which have appeared dealing with professional associations have not generally dealt with the development of structural organization. Furthermore, librarianship has not been the subject of comparative studies as have other professions. A need exists for the study of the organizational structure of professsional associations in general, and in the association for librarians in particular.[2]

The purpose of this study is: to review briefly the chief characteristics of professional associations and delineate three primary problem areas, relating to organizational structure, for closer examination; to trace the historical development of the organizational structure of the American Medical Association and the American Library Association; to describe in some detail the current structure of the two associations; to analyze briefly several selective features of the two associations which give insight into their operation; to discuss the responses to the three problem areas suggested in the theoretical background of the study; and finally, to present some general observations and conclusions.

II.

Occupational associations are good examples of the mutual-benefit association, following the classification of Peter Blau. Their primary purpose is to serve their members. The goal is establishment of occupational identification. The functions of such associations fall into two broad areas: (1) "safeguarding of the traditional rights and privileges of the occupation against competing areas of society," and (2) "concern with the internal organization of the occupation and control over its practitioners."[3] The association looks both outward and inward.

Professional associations are simply the occupational associations of the various professions. They differ from other associations, such as unions, only because of the relative status which the members of the profession have in society and the consequent means that are utilized to achieve goals. A profession has been defined in several ways, but the elements are common. One definition is:

> an occupation involving highly specialized knowledge and skill, usually of a highly esoteric or scientific nature, and acquired by special, intensive and extensive, advanced, formal instruction and training. This knowledge is so specialized and profound that the benefiting public does not have either the knowledge or proficiency to judge the services.[4]

The ingredient of public accountability is an important addition to the description of the professional. Altruism and social status are both linked to the opinion that society at large has of the professional.

An assumption of this study is that the two occupational groups being studied--physicians and librarians--are members of a profession. It is also assumed that the American Medical Association and the American Library Association are professional associations; in the case of the latter, as will be seen, the assumption may be questioned. A further assumption is that the organizational

structure of each occupation's national professional association, and its development over time, will aid in understanding the nature of the profession itself.

A "physician" for the purposes of this paper is considered one who is legally qualified to practice medicine, through education and subsequent state licensure. The American Medical Association maintains a listing of all physicians in the country, regardless of medical association affiliation.[5]

A "librarian" for the purposes of this paper is considered one who is trained in library science and engaged in in library service. This is reflected in education requiring the masters' degree in library science or the holding of a position where this educational requirement obtains. The U.S. Office of Education collects statistics and makes biennial estimates.[6]

A study of this nature has several limitations. First, the topic is a large one and one could wish that more time might be spent on a segment of the subject, for example, the historical evolution of each association. But the purpose of this paper is to provide an introduction only. Second, most of the present study is based on printed literature sources; little original data gathering has been attempted. Rather, printed documents have been utilized, such as association reports, constitutions and by-laws, directories, management surveys, and the official professional journals. Many of the generalizations may be supported by other studies, for example the reports by Oliver Garceau dealing with each association. But for matters of detail, original analysis still remains to be done. A third limitation of the study is that some important material for a study of this nature is not available. For example, the current constitution and by-laws of the American Medical Association are not available even at the Association's library. No comprehensive history of the American

Library Association has been written; information must be painfully gleaned from the official journal.

The study of organizational structures of professional associations is a complex subject. In order to provide some focus in the examination which follows, three problem areas have been selected for more close attention. In formative periods of professional associations, the organization is usually small, the members highly involved at every level, and the unity of the group is apparent because that is what brought the members together initially. However, as development occurs issues of internal democracy and internal unity assume importance.

Internal democracy involves dealing with two problems: membership apathy and oligarchical control.[7] Over time, the mutual-benefit association ideal of highly involved members participating in reaching a common goal is altered, so that centralization of control predominates and with it, a ruling oligarchy. The unity of the profession is threatened as it develops specialized branches. The third problem is the segmentation of the profession and the manner in which it is met by the association.[8]

The three primary problem areas relating to organizational structure--participation of the membership, role of the leadership, and segmentation of the profession--will be considered after some understanding is gained regarding the historical development of the two associations and their structures are described and analyzed.

III.

The American Medical Association was officially organized in 1848 with 195 delegates in attendance, following two years of formative meetings.[9] The primary justifications for establishing a national medical organization were the

need for improvement of medical education and for a uniform code of ethics for the profession.[10] The Association made slow progress on each of these matters in the period before 1900. Despite the labors of the Association's Committee on Medical Education, the number of medical schools increased and the quality was very uneven. At the end of the century, there were 156 schools, of which less than half were affiliated to colleges and universities, and more than 24,000 students were enrolled.[11]

The matter of codes of ethics was also difficult to deal with. Branches of the healing profession, called by the Association "sectarian" or "cultic," were strong in the nineteenth century. Various medical philosophies such as homeopathy, eclecticism, chiropractic, and osteopathy sought inclusion in the medical profession. While other national associations were formed to embrace them, the American Medical Association steadfastly resisted efforts to bring non-scientific medicine into its ranks.

The national association was also troubled by the multiplicity of separate groups scattered throughout the country. In addition to racially separate groups, there were geographical and specialty organized bodies. Regional groups, such as the Mississippi Valley Medical Association, assumed importance in areas where their constituents were active. Specialty groups, such as the American Opthalmological Society (founded 1864), grew in number in the late eighteen hundreds. When the Congress of American Physicians and Surgeons was created in 1887 to represent these specialized groups, the American Medical Association was concerned lest its prerogatives be assumed by a federated group.

With these bodies competing for the allegiance of the medical profession, the American Medical Association needed, but lacked, strong organization. It rested on a base it refused to incorporate fully, and consequently it received

little support. Membership in the Association consisted of those who served as delegates to national conventions, present and past, and a limited number of physicians who were admitted "by invitation." As for the Association's representation, delegates came from four sources: (1) each county, state, and district society was allowed one delegate for every ten members; (2) regularly constituted medical schools were permitted two delegates each; (3) professional staffs of larger hospitals were each entitled to two delegates; and (4) permanently organized medical institutions recognized by the Association could send one delegate.[12] In 1874 representation was restricted to the various societies. However, even if the societies had sent their full delegations to a national convention, there would have been more than two thousand delegates. This situation fortunately did not occur.

The establishment of the Journal of the American Medical Association in 1883 did much to bring the diverse segments of the profession together and provide a medium for propagating the opinions of the Association. Even though its voice was not yet strong, the Association exerted its influence to insure uniform reporting of vital statistics by the federal and state governments and to urge the establishment of a federal department of health. The nineteenth century experience of the Association in attempting to mold the profession and to influence society for the enhancement of the profession provided a sort of proving ground and a valuable reservoir of practical knowledge for the years ahead.

In 1901 the Special Committee on Reorganization, headed by Joseph N. McCormack, reported to the Association and recommended the adoption of a revised constitution. This reorganization symbolized a new aggressiveness within the Association and the procedures that were inaugurated at this time have continued

to the present time with only slight modifications.

The new constitution provided for open membership for all bona fide members of county societies who paid the fees of the Association.[13] Representation to the restructured House of Delegates was determined by the state associations which were entitled to one delegate for every five hundred members or fraction thereof. The total number of delegates was limited to one hundred fifty and reapportionment was to occur every three years. The House of Delegates elected the officers, including the Board of Trustees, from outside its ranks. The organization of a cohesive and relatively small legislative body enabled the Association to act in a unified way. In order to make the new arrangement function properly, state organizations needed to be formed, where they were lacking, and county societies had to be established. Throughout the rest of the decade, McCormack led a determined crusade for the establishment of component (state) and constituent (county) societies. This brought the significance of the American Medical Association to the local practicing physician.

The committees and councils provided for in the new constitution began to operate also. The medical profession was becoming active on several fronts. The Council on Medical Education assumed responsibility for reporting on the condition of medical schools and the classification of them in 1905.[14] In 1907 the first list of approved schools was released. The publication of Flexner's report on the state of medical education lent added authority to the Association's efforts to make the approbation of medical schools a condition for survival.[15] Within twenty years the number of schools had been cut in half.

The growing supremacy of the American Medical Association within the profession was further enhanced by the provision in 1913 that all members in good standing in local and state societies would be members of the Association,

regardless of the payment of dues. "Fellows," members who paid the fees, also received the Journal. The enlarged membership was reflected in the growth of the Association, which reported 8,401 members in 1900 and 83,338 members in 1920; fellows numbered in excess of forty-seven thousand.[16]

Following the decade or more of strengthened organization and numerical growth, political activity continued to increase, but the organizational and public relations work of the Association declined during the years of World War One. Along with medical education, the Association increased its active concern for favorable legislation. The Committee (later Council) on National Legislation and the National Auxiliary Congressional Committee, which had members in most county societies, worked together to bring the influence of licensed physicians to bear on legislators and government officials. The first directory of 1907 came into being at this time to expedite communication. The Association supported federal food and drug legislation and worked to privide implementation of the Pure Food and Drugs Act of 1906. The Association was unsuccessful in its attempt to insure the creation of a federal health department and opposed the move of the Progressives to inaugurate compulsory health insurance under government regulation.

The aftermath of the First World War brought a realignment of the Association's policies. Organized medicine had won the battle for its own profession and its primary antagonist now appeared to be government. "The AMA shared the general disillusionment of a nation that had found the fruits of victory bitter and that glanced with growing suspicion on compulsory health insurance and other social experiments of recent European origins."[17]

The measure of security that the Association had enjoyed during the nineteen twenties was shaken by the Great Depression in the nineteen thirties. The economic hardship exposed issues that had been hidden before. The Roosevelt administration,

concerned with the physical condition of the American populace, sought the cooperation of the medical profession. The initial response of the Association to the public health measures of the New Deal was cautious approval. Both the social security and compulsory insurance programs were opposed on the grounds that the medical profession was endangered by the possibility of outside interference. Although it cooperated in the President's National Health Conference in 1938, it did not endorse the proposals for federal action. Voluntary health insurance was also opposed because of the threatened autonomy of the medical profession.[18] However, as these programs became increasingly attractive as an alternative to compulsory health insurance, the Association sought to control the direction of the movement for its own protection. In 1938 the Department of Justice initiated proceedings against the Association for alleged violation of the restraint-of-trade provision of the Sherman Anti-Trust Act, charging that the Association had attempted to inhibit the operation of a group hospitalization plan in the District of Columbia. The case was settled in 1943 when the Supreme Court upheld the judgment of a lower court, but exempted the Association from prosecution. The litigation resulted in loss of prestige for the Association.

World War Two brought the problems of government control of medical services to the fore not only on the military fronts, but on the domestic scene. The Association concentrated on helping the hundreds of physicians in the armed forces to recover their positions throughout the nation. As the wartime regulations were rescinded, the profession attempted to recover its independent stance once more. It resisted an enlarged, federally sponsored veterans' program, including great expenditures for hospital facilities. The rationale was the same. The patient must exercise independent choice of physician for individual services rendered.

The progressivism of Truman met the opposition of the Association, as did that of Roosevelt. The health provisions of the Fair Deal served to polarize the issues into two sides. The Association united behind free medicine and gained a reprieve when the Republican conservatives regained power in Congress. However, the Truman victory of 1948 served notice for the Association to prepare for Armageddon.

The Eighty-First Congress, 1949-1951, provided the battleground.[19] The activities of the Association to fight the administration's health insurance program during this period probably represents the most concerted effort on the behalf of organized medicine. The story is as exciting as one would care to read. The leadership painted a grave crisis for the independence of medicine to both the profession and to the voting public. With an assessment fund backing of more than two million dollars, the distribution of fifty-five million pieces of literature, and a vicious attack on the Democratic party, the Association was able to appeal to the American public and in the elections of 1950, the cause of organized medicine triumphed.

During this 1949-1950 campaign, the Association assessed all of its members a non-compulsory twenty-five dollars.[20] In 1950 no assessment was made, but instead Association membership dues were reestablished at twenty-five dollars; the fellowship was abolished in 1952. Thereafter, membership in the county and state society no longer carried the privileges of Association membership without payment of additional fee. The percentage of physicians belinging to the Association declined after 1950. The growth of institutional and group practice and disenchantment with the politics of organized medicine has probably had more to do with the decline than the establishment of dues.

The high point to date in the history of the American Medical Association

was reached in the 1950 election. In the early fifties, it lent its voice to those supporting the general allegations of the late Senator Joseph R. McCarthy and it endorsed programs to investigate possible cases of the undermining of traditional American principles of free enterprise and individual initiative.

The Eisenhower years were quiet ones in the camp of the Association. The moderation of the administration seemed to modify some of the more extreme political goals of the Association. The expanded proposals for medical care of the Kennedy–Johnson administrations again prompted the Association to action. In 1961 the American Medical Political Action Committee (AMPAC) was organized for the political action that was forbidden to the Association per se. The funds that were gathered were directed toward electing candidates favorable to organized medicine in principle and program. In 1965 the Association marshalled its vast financial resources to combat unsuccessfully the medicare bills.[21]

Only a brief sketch of the Association's history may be attempted here. And the focus has been on the organizational changes. After the constitutional changes of 1901 and the organizational decade that followed, the key dates to note are the expansion of membership in 1913 and the reimposition of dues in 1950. The current organizational structure, as it is described in the following section, should bring the present mechanics of the Association into clearer focus.

A brief description of the current organization of the American Medical Association will provide a basis for later analyses.[22] In the United States there are some 2000 county medical societies,[23] components of the Association, which elect delegates to state associations or societies, constituent bodies of the Association. State associations elect delegates, in turn, to the national House of Delegates for two-year terms at the rate of one for every thousand members or

fraction thereof.[24]

The House of Delegates, presently composed of 242 members, meets semi-annually. In addition to the state association delegates, one delegate each represents the five government services (Air Force, Army, Navy, Public Health Service, and Veterans Administration) and twenty-seven delegates represent the specialty sections of the Scientific Assembly, the Association in general assembly. Thus, in 1968, 210 delegates represented the state associations and the balance the special interest groups. The elected Speaker of the House appoints members of the House's committees and councils.

The House of Delegates elects from outside its ranks the Association officers: President, President-Elect, Vice President, and Secretary-Treasurer; each official is elected annually. Twelve members, not from the House of Delegates, are elected to five-year terms on the Board of Trustees which includes also the President, President-Elect, and the Immediate Past President. The Board appoints the Executive Vice President who is responsible for daily operation of the Association's headquarters machinery as it works through nine divisions;[25] he serves at the pleasure of the Board. The President with the approval of the House of Delegates appoints the members of the standing committees. In this category there are eleven councils and twenty-nine committees and commissions, including such groups as the Council on Drugs and the Council on Mental Health.

Twenty-seven specialty sections are presently authorized and meet regularly at conventions. These, including sections on anesthesiology and orthopedic surgery, elect officers annually and, as mentioned above, are represented in the House of Delegates. The specialty sections currently issue ten specialty journals, including, for example, the Archives of Dermatology and the Archives of Neurology.

In 1915 the National Board of Medical Examiners was established. It is a

> voluntary and semi-official examining agency. The purpose of the organization is to prepare e to administer qualifying examinations of such high quality that legal agencies governing the practice of medicine within each state may, at their discretion, grant successful candidates a license without further examination for those who have successfully completed the examinations of the National Board; and who have met such other requirements as the National Board may establish for certification of its Diplomates.[26]

The Board includes representatives of the federal services, the Federation of State Medical Boards of the United States, the Association's Council on Medical Education and Hospitals, and the Association of American Medical Colleges. In 1933-1934 the Advisory Board for Medical Specialties was established to coordinate the advanced certification programs. At present twenty boards, including the American Board of Internal Medicine and the American Board of Urology, examine and certify candidates.[27]

The Association approves more than eighty-seven national scientific medical societies which meet its requirements. Such varied groups as the American Broncho-Esophagological Association and the Society of University Surgeons are approved at the present time. These societies will be treated further below.

The organizational structure reflects the primary responsibility of the Association: "as the representative of the American medical profession, to continue to foster the advancement of medical science and the health of the American people." Eleven areas of activity make this general purpose more specific.[28]

IV.

The American Library Association was organized in 1876 with 103 registrants in attendance at the first sessions in Philadelphia at the time of the Centennial Exhibition.[29] The original 1879 charter listed the basic objective of the Association as:

> promoting the library interests of the country by exchanging views, reaching

> conclusions, and inducing cooperation in all departments of bibliothecal science and economy; by disposing the public mind to the founding and improving of libraries; and by cultivating good will among its own members.[30]

The current constitution lists the simplified purpose of the Association as to "promote library service and librarianship." Membership is open to anyone "interested in the work of the Association."[31] The fraternal spirit continued for some years when the organization was small. Very soon, however, librarians in special types of libraries began to form subdivisions of their own for exploration of topics of common concern. In 1889 the college and reference librarians formed the first of what would be many sections of the Association.

By the end of the first decade of the twentieth century, the membership and other responsibilities had grown to the extent that a paid secretariat was necessary and in 1909 through a subsidy of the Carnegie Corporation and space donated by the Chicago Public Library a permanent headquarters was begun. In 1907 the ALA Bulletin began to be published; the Association had its own journal.

During the World War the Association helped to establish libraries for the armed services and upon the conclusion of the War founded an English language American Library in Paris. Throughout the nineteen twenties, public libraries expanded, even without the pre-war Carnegie buliding grants. The profession's attention was drawn to problems in library education. The establishment of the Board of Education for Librarianship in 1924 for the purpose of accrediting library schools was followed shortly by the founding of the Graduate Library School at the University of Chicago. Both events seemed to offer the beginning toward a solution.

While the Association had been small, a relatively few persons were able to oversee the work. As membership increased and headquarters tasks grew in number, the need for study of the organization became apparent. Between 1920 and 1930

the membership trebled. Thus, in 1928 a proposal was made to establish a committee to conduct a review of the Association's activities, consider the effectiveness of current practices, and recommend changes in policy. The First Activities Committee made its report in 1930 and listed six objectives for the Association to achieve in professional accomplishment.[32] Little was said about organizational structure, except that a more adequate headquarters library was needed and that the committees and sections needed more funds. Expansion and centralization of Association activities were encouraged; "the natural conservatism of many of our members will guard against serious errors."

The Second Activities Committee reported in 1934. Less criticism was voiced of the professional programs of the Association. Three offices were recommended: (1) a statistical and research bureau, (2) a department for college and university libraries, and (3) a department for library work with children and youth. The multiplicity of overlapping committees and perhaps the economic situation prompted the Committee to recommend that more lay committee work be encouraged and that less of a burden fall on the strained headquarters staff. The reduction of the number of committees was also suggested.

In the period following the report, sections and special interest groups continued to grow and be created. These groups established their own dues, formulated their own criteria for membership participation, and largely ran their own affairs. With the lack of central authority, the office of Executive Secretary became dominant. The strength of the headquarters organization and the move on the part of the Association toward obtaining federal aid for public libraries resulted in dissatisfaction among the sections. Pressure mounted for a more democratic and representative form of government and recognition of special interest groups.

The Third Activities Committee made its report in 1939 and it reflected the tensions that threatened the continued existence of the Association. Organizational matters were almost the exclusive concern of the Committee. Two chief recommendations were made. First, the Council of the Association was made completely elective and representative of geographical and special interest groups. These groups began to elect councilors by the same formula, based on membership. In 1947, for example, there were 142 voting members of the Council. In addition to the twenty-four members who were elected by the membership at large for four-year terms, seventy-four represented geographical chapters and thirty-seven represented divisions.[33] This arrangement gave greater strength to the special interest segments of the Association and to the geographically powerful sections of the country.

Second, the report recommended the creation of divisions representing distinct fields of activity. Six divisions were authorized in 1941 and by 1946 there were a total of eight. Each division was to receive a stated portion of its members' dues and was to have complete autonomy over its professional and fiscal affairs. A graduated dues scale was adopted that provided for the ability to pay.

This effort to make the Association a grass-roots organization was admirable. But in the process the headquarters organization suffered in financial support and in professional prestige. The issue at stake seemed to be the conflict between a membership group and national central authority. But, whereas the proliferation of groups was designed to encourage member participation, the dispersal of activity actually brought more burdens to the headquarters staff without an increase in authority or funds. Oliver Garceau evaluated the developments under the implementation of the Third Activities Committee report thus:

> Obviously it is almost certainly hopeless to carry on the operations of a national group at the grass roots level, however appealing it may be in theory. ALA has made a sincere effort to do so, and as a result the energies of the staff have been scattered and the association's budget has been strained to a dangerous degree. The divisions have been disappointed in the staff and resentful of the Executive Secretary's initiative and independence.[34]

The war years prevented the implemenation of complete decentralization, however. The staff was active; the new post-war Washington, D.C. office is one example. But conditions grew worse.

In 1948 a Fourth Activities Committee made its report to the Association. Recommendations were made regarding both the management of the headquarters staff and the membership organization. No matters dealing with professional activities or programs were raised. The report was critical of the headquarters management, which it claimed was inefficient though "loyal and hardworking."[35] Specific responsibilities of the staff were outlined and suggested economies were presented.

With regard to the membership organization, the Committee recognized that decentralization had not brought a significantly larger number of members into the Association's activities. The need was expressed for more of the authority of the Council and the Board to be spread to the divisions and the headquarters staff alotted accordingly. The Council was to include representatives from geographical (usually state) associations, which upon application would become chapters of the Association; these elected one councilor for every 300 members, regional associations at a rate of one councilor for every 600 members. Divisional councilors were elected on the basis of one representative for the first fifty members and one additional for each 250 members beyond that. Twenty-four councilors were elected by the Association at large. The Council also included the thirteen members of the Executive Board elected at large; one councilor from each affiliated organization; and without vote, past presidents of the Association,

chairmen of boards and standing committees. By 1954 there were 208 voting members of the Council; Eighty represented chapters and eighty-two represented divisions.

Other recommendations provided that the divisions of the Association be divided into two groups: three departments of functional type-of-activity units and four associations of substantive, type-of-library units. Each division was to receive headquarters staff and Council representation. Miscellaneous recommendations were made dealing with housekeeping chores. Although the Council was restructured, the major recommendations regarding the establishment of organizational units were not accepted, and the implemenation of the report was at best only partial. More study or organizational problems followed.

During the years of study several developments occured. The divisions increased in numerical strength and in number. The number of round tables (eligible for establishment on the petition of fifty or more Association members engaged in similar pursuits), boards and committees increased and expanded in an uncoordinated manner. Financial and staff support for the various units remained a problem; the divisions required increasingly more money to finance their autonomous programs. Endowment funds increased in capital gains and book value, despite the withdrawal of $221,000 to subsidize division programs. Publishing ventures by divisions and the Association as a whole resulted in increased expenditure but less coordination. Special interests made general conference planning difficult. The relationship of the Executive Board and the divisions in matters such as project grants had not been satisfactory.

By 1954, fragmentation of interest had caused Association members to lose sight of the broad objectives which had originally united them into a common organization. Frustration of special interest groups and those favoring a strong central control of the Association finally resulted in the commissioning of a

management survey of the Association by the firm of Cresap, McCormick and Paget, partially underwritten by Carnegie Corporation and Association funds. The report of the consultants, released in the Spring of 1955 and approved by the Council in July, has been the basis of the present organization of the American Library Association.

The survey listed five weaknesses of the headquarters organization. These dealt with the lack of coordination between the various divisional executive secretaries and the Association Executive Secretary and with the lack of authority for the Executive Secretary to effect general action and coordinating supervision of Association programs and thus to promote economy of operation. The member organization was charged with seven weaknesses:

1. The organization lacks a central governing body or "top management."
2. Responsibility and authority are not clearly defined and matched.
3. Responsibility and authority are loosely dispersed in the organization.
4. The scheme of divisions is not sufficiently comprehensive.
5. The Council and Executive Board are involved in too much detail.
6. There is insufficient integration of the activities of the ALA and its chapters.
7. There is inadequate organizational provision in the ALA for state librarians.[36]

Seventeen conclusions were drawn from the study and a recommended structural organization was presented. Since these provisions were implemented with a few modifications, they will be dealt with below when the current organizational structure of the Association is described. The summary of the recommendations provides the flavor of their intended effect.

> These recommendations are designed to halt the trend to organizational separation and program disintegration within the ALA. They are intended to promote a cohesion and essential unity through bringing librarians closer together rather than forcing them farther apart. The proposed reorganization should increase the capacity of the Association to accomplish its broad objectives, to the increased satisfaction of its members of all classes and divisions.[37]

A description of the current organizational structure of the American Library Association will be helpful for seeing the Association as it operates at the present time.[38]

The Council of the Association is the basic governing body of the organization.[39] Currently it is composed of councilors from several sources. Ninety-six members are elected at large, twenty-four each year for three-year terms. The fifty-four state and regional associations are entitled to one councilor each, which are usually elected annually by the respective memberships. The fourteen divisions are represented by their annually elected presidents and additional councilors for every fifteen hundred members. The eleven currently affiliated associations are entitled to one councilor each. Past presidents (currently twenty-seven) are members of the Council. The elected officers of the Association--President, President-Elect, Second Vice President, and Treasurer--the past president, and the Executive Director are also members of the Council, although the Executive Director has no vote.

The Council elects eight members of its body to serve four-year terms on the Executive Board with the elected officers, the past president, and the Executive Director, who is appointed by and serves at the pleasure of the Board. All Committee and other appointments not provided for elsewhere are made by the Board.

Fourteen divisions have been established by the Association. They include five type-of-library Associations and nine type-of-activity divisions. Examples of the former are the Association of College and Research Libraries and the Public Library Association. Examples of the latter are the Resources and Technical Services Division and the Library Education Division.

Forty-one committees function under the authority of the Executive Board and the Council, including thirty-five at large committees of the Association

and six joint committees involving several separate organizational units. An example of an important committee is the Committee on Accreditation. Eight round tables, consisting of more than fifty Association members, are presently functioning. An example is the American Library History Round Table. Neither the committees nor the round tables are represented directly on the Council.

Eleven national organizations "of kindred purpose" which are affiliated to the Association enjoy one councilor each. Examples of such bodies are the Association of American Library Schools and the Medical Library Association.

The Executive Director is responsible to the Executive Board for the operation of the headquarters. Five divisions function under his supervision: administrative, divisional, publishing, fiscal, and legislative services.

V.

An understanding of the formal organization of a professional association is not sufficient in itself, if one is to appreciate the real working of a professional group. Other matters are crucial to the manner in which an association functions. These factors are referred to in this paper collectively as the basis of power and influence. For each of the associations under study the following subpoints will be briefly considered: (1) administrative control, (2) professional power, (3) financial support, and (4) political influence.

The concept of administrative control involves determining where the real roots of power in the organization lie; these may or may not be apparent from the formal structure of the institution as laid down in a constitution. But the seat of actual power is important to determine; for an understanding of this will reveal much about the working of the association and thus, the profession.

Within the American Medical Association the real power lies in the elected general officers and the power increases with diminishing opportunity for review

by the electorate with the level of office held. The only direct vote on any issue is the election of officers on the county level.[40] After that has occurred other matters are decided by the voting of representatives. Furthermore, even the elections in local societies make a popular discussion of issues and candidates difficult. The nominating committees are usually appointed by the local presidents, assuring current leadership of some influence in the choosing of its successors. These nominations are rarely contested, especially since solicitation of votes is forbidden.[41] The dominant faction in the Association or the profession is thus able to continue its leverage indefinitely. The power becomes progressively great and to some extent less responsive to the needs of the local societies. The county delegates elect the state delegates who elect the members of the House of Delegates who in turn elect the Board of Trustees, the members of which serve a three-year term.[42]

Since the overwhelming block of the members of the House of Delegates comes from the constituent state chapters and not from the directly elected scientific sections of specialization, the power of indirect election is perpetuated. This subject will be further discussed in the unit below dealing with membership participation and the source and role of leadership.

To point out the basis of administrative control in the American Library Association is not as simple as with the American Medical Association. The development of the Library Association, as seen above, has brought various groups with power to the fore at different periods in the Association's history. At first the real power lay with the few leading and founding fathers, then it shifted to the headquarters staff. After the Third Activities Committee recommendations were implemented, the power lay increasingly in the hands of the officers of the special interest divisions. From 1956, as a result of reorganiza-

tion, power has tended to concentrate in the Council and the Executive Board, elected by the membership at large and the Council. Unlike the American Medical Association in which the House of Delegates is composed almost exclusively of geographically representative delegates, the American Library Association Council is composed of a variety of representatives. The geographical chapter representation is not proportional to size of membership and together is of about equal weight as the special interest divisional representation. The largest single block of councilors is the group of ninety-six that are elected at large for four-year terms; these members of the Council represent about forty per cent of the total strength.

While there has been some complaint that the Council is becoming too strong, there appears to be ample representation of divisional interests and other points of view. For example, twenty-seven past presidents are voting members! Since the representatives of divisions and other groups, such as affiliated associations and committees change every year, the Council is not a static body. The problem may be just the reverse of the House of Delegates. The Council is so democratically selected and flexibly constituted that it sometimes lacks the stability and continuity to guide a national professional association.

The matter of professional power is an important one, because the structural organization of a professional association provides an indication of the power of that the association has over the profession it claims to represent. Professionalism in an occupation is shown by various activities in which the members are affected by the association.

The American Medical Association is viewed by most analysts as one of the best examples of a "free professional" association. Medical practitioners are united by a common interest in augmenting the effectiveness and integrity of

their profession. Both a recognition of public duty and of personal benefit lie behind the consent that the medical profession gives to the Association to govern itself.[43] The consent which the Association enjoys has enabled it to become a monopoly in the profession.[44] Competing groups, when they have existed, have not seemed to promote the unity that physicians find essential to their wellbeing. The growth of the Association's influence and the absense of any alternative professional affiliation has left the doctor with little choice but to join.

The position of monopoly has enabled the Association to apply coercion in several fields, sometimes utilizing legal means and at other times exercising solely professional power. Codes of ethics have been enacted into state laws. However, the standards of local societies are much more stringent than legal ones. The Association also exerts professional power in the accreditation of medical schools and hospitals.

The greatest power over the profession is admittance and retention in the Association itself, as reflected in membership in the county society.[45] Rejection or denial of membership is a serious, almost insurmountable handicap to the independent practitioner. Such a person will be ineligible for specialty board examinations, referrals or consultations, and the use of certain hospitals, to say nothing of the effects of the stigma attached to such a situation. Non-members who are qualified for membership, but are excluded for racial or other grounds are not usually treated in the same manner, and may even expect the cooperation of members. Punitive tactics amounting to a partial revocation of the licensure to practice medicine are felt primarily by those who have been expelled or rejected by a local society. Few physicians have the practice or reputation to risk such a possibility. The authority of the national association as exercised by

the county society and its members is a powerful force for keeping the profession together and enforcing its discipline.

The professional power of the American Medical Association is great and is scarcely duplicated by any other profession. The American Library Association has very little power over its members in professional standing by comparison. Membership in the national association is a requirement for few positions, though most of the leaders in the profession are members. Two possible reasons on the organizational level may account for this situation in part. First, the Association is not directly tied to the state associations. While the state associations are considered chapters of the national association, membership in them is not related to membership in the Association.[46] Second, there are virtually no requirements for membership in the Association except "interest in the work of the Association."[47] Furthermore, there are sixteen types of memberships available for any person or organization desiring to receive the benefits. These are grouped under categories for personal, organization, and special members. Even the description of Personal Members--Librarian Members is broadly inclusive and applications are most certainly never verified.

At this point the role of the Association in professional development may be debated. The Association enjoys its tax-exempt status because it is an educational association, yet it attempts to perform some of the functions of a professional association. The profession suffers as a result, since the broad objectives are emphasized at the expense of specific programs aimed at the practitioners.[48]

The Association has exerted some power in accrediting library schools and establishing boards for certification in some states. Most academic and many larger public libraries require that a staff member have received his graduate

library school training at an institution accredited by the Association. Membership in the Association is viewed often as a professional duty, rather than a professional necessity. The Code of Ethics is seldom used as a basis for expulsion from the Association and never from the profession. In short, the professional power of the American Library Association seems to lie in the direction of libraries rather than in librarians. Standards have been devised for institutions but not for those who labor in them. One critic has suggested that the Association is actually functioning to aid libraries and not the profession.[49] Instead therefore, of being compared to a professional association such as the American Medical Association, perhaps it should be thought of as an institutional association like the American Hospital Association.

The financial support of the two professional associations being studied differs significantly. In both professions, the national association draws on the support of its members to finance operations. The medical profession, one which enjoys an average income higher than any other professional group, draws heavily on its members through county society assessments, state dues, and national dues. The major assessment is at the local level, where in the early nineteen fifties the amounts came to as much as $125 per year in some societies.[50] State dues at that time ranged from $20 to $55 annually. These figures must have been raised, at least doubled, in the last fifteen years. The national dues, since 1966, have been $75 per year.[51] American Medical Association income is augmented by the sale of publications and the accompanying advertisements. The Association does not collect dues from members directly, but instead allows the county societies to collect the combined dues of all levels of membership.[52]

The American Library Association collects dues for its own use, since the state chapters are not as closely tied to the national organization. The dues

structure is complicated.[53] Personal memberships can range from $6 to $50 depending upon income. Institutional memberships vary likewise from $10 to $250 depending upon annual expenditure. Special memberships, which resemble rewards for charity, begin at $75 and reach $1000.

The amounts of annual income and expenditure for the two associations provide a contrast.[54] Although latest figures on the American Medical Association are not available, according to estimates the income must be well over $25 million. The figure for American Library Association income is $2.7 million for the fiscal year ended August 31, 1968. There are several similarities in the annual budgets, however. Both associations can claim that approximately one third of their budgets are met by membership dues.[55] They both report that more than fifty per cent of the annual budget is met by publications sales, including journal subscriptions and advertising.

The balance sheets for the last recorded period showed the American Medical Association figure at $23,523,569.15 (December 31,1967) and the American Library Association figure at $6,917,997.76 (August 31, 1968).[56] The total assets, liabilities, and reserves of the Library Association represented about 29.4% of those of the Medical Association. A word may be said about the investment-securities and the endowments of the respective organizations. The Medical Association has in excess of seven million dollars in United States government securities and common stock. The trend has been to invest more heavily in common stock in recent years, since 1960. The Library Association has endowments in excess of four million dollars, with an additional one million dollars in United States treasury bills and certificates of deposit. A final comparison is possible between the values of the land, building, and equipment of the national headquarters. The medicine figure is placed at $9,260,809.17 and the library figure is placed at $2,142,895.43.

The American Medical Association is clearly ahead of the American Library Association in the amount of the annual budget, but the demands are much greater and the income is available. Beyond the operations budget, the Medical Association distributed $4,524,919 through its Education and Research Foundation in the last fiscal year.[57] The Library Association spent $852,665 on special activities and projects. The funds for this kind of endeavor derive from various voluntary sources.

Political influence is a desirable power in the hands of a professional association because through it the profession may safeguard itself and its effect on society with the sanction of government. This single area of professional expression has been discussed in detail, and it is not the purpose of this study of organizational structure to do more than simply mention this area as an important one.[58]

The political strength of the American Medical Association may be attributed in large part to the status of the physician in society.[59] The public trust in medical science extends beyond medicine into economic and political areas which touch on health. Because of the support and authority of the Medical Association, as given to it by the profession, lawmakers are disposed to heed the opinions of organized medicine.[60]

One of the historic purposes of organized medicine has been to attempt to influence governmental decisions. As long as regulation and medical legislation was carried on at the state level, the national movement was not directly involved. However, in the twentieth century, the situation has changed considerably. The Association is active on the federal, as well as state and local, levels. One may note, however, that the wisdom of establishing a separate political group was doubted in 1944.[61] As a professional association, the tactics do not so much

involve direct contact with legislators; rather, the Association expends enormous funds to influence public opinion to favor its policies. In 1949 more than two million dollars was inserted into politics.[62] The American Medical Political Action Committee (AMPAC) was created in 1961 to carry on the political activities which were forbidden to the Association per se. During the first quarter of 1965, while the debate on medicare was the hottest, the Association spent more than $950,000, breaking all records for expenditures by lobbyists.[63] Although its opinions are not always heeded, at least they are heard.

The Association on every level lends support to allied professions when the situation is deemed necessary and advantageous. The medical profession establishes advisory committees to foster the continuing relationship of the profession with various public administrative agencies, particularly on the state level. The authority and financial resources of the Association combined with political influence make organized medicine almost a quasi-legal force in any area dealing with medical affairs. "The political authority of the state itself has in effect been delegated to organized medicine."[64]

The American Library Association has been more reluctant to enter politics, particularly legislative action, than has the medical profession. Two motives have been suggested for this: (1) ideological dislike for the pragmatic conflict of politics, supported by a feeling of weakness and insecurity and (2) traditional development of libraries as local, rather than state or national, institutions.[65]

The central place that the Library of Congress has played in the development of American libraries has been indispensable, yet since it is under the direct control of Congress, the need became apparent for some other agency in the Executive Branch to aid in the extension of library services. Behind this issue, the

Association entered the political arena in the nineteen thirties, and the result was the establishment of the Library Services Division in the Office of Education. Several pieces of legislation were supported during the New Deal era.[66] The Federal Relations Committee reflected the growing involvement of the Association in government. This was further implemented by the establishing of the permanent Washington Office in October 1945. The passage of the Library Services Act of 1956 was a triumph for the library lobby. Since that time the Association has supported programs involving related activities allied to libraries, such as the Elementary and Secondary Education Act of 1965. Similar support for state legislation has been encouraged on the state level by chapter associations.

The political activity of the American Library Association has concentrated on the legislative field, with occasional success in the Executive Branch, such as the establishment of the National Advisory Commission on Libraries in 1966. Various states have advisory committees, similar to those of the medical profession described above, which seek to influence decisions regarding library matters.

The objections or explanations of the reluctance of the Association to enter pressure politics may be disappearing. They certainly do not limit the activity of the Medical Association, even though medicine is considered one of the most "free" professions. The tax-exempt educational association status which the Association so covets may prevent it from assuming the role of an effective lobbyist for the personal members of the profession. Financial resources may be a chief limiting factor for the Association, as well as the inability to generate public support.[67] One may further note with interest that the same issue—federal aid affecting the profession—brought both associations into the political arena. Opposition to "socialized medicine" activated the Medical Association to take a position. After considerable debate on the desirability

of federal aid for library services, the Library Association sought and supported federal assistance to libraries.

VI.

The historical survey, description and analysis of the organizational structures of the American Medical Association and the American Library Association above have provided some preparation for a discussion of the responses to the three primary problem areas suggested in the theoretical introduction to this study. The problems are: (1) participation of the membership, (2) role of the leadership, and (3) segmentation of the profession. The manner in which each association has dealt with, or is currently meeting, these issues will be explored. These areas are not unrelated and each one affects the other two.

Participation of membership in an association signifies more than mere membership status, though that is certainly the starting point. Since World War One the American Medical Association has enjoyed the support of more than half of the physicians in the country. The high point to date was the early nineteen fifties when more than seventy-five per cent of the nation's doctors were members.[68] At present non-members consist primarily of doctors not in private practice, such as those in the armed forces, public health officers, medical school professors, and physicians engaged in research.[69] (Black physicians, excluded from Association membership because of county exclusions, are members of the National Medical Association.) A 1960 study indicated that only 35% of the physicians not in private practice were Association members.[70] However, of the physicians engaged in private practice, probably about 90% are members of the Association.

As seen above, the only place where all members have a voice in the policy-making apparatus is at the county society level. However, even that opportunity

may be missing in some local societies.[71] After that, business is conducted by delegates, increasingly removed from the membership. Even the attendance in local meetings is low, not over ten per cent of the membership by one estimate. Less than two per cent are actually active in society activities.[72] Several reasons have been advanced for this situation. One has been alluded to above. Dissent is discouraged in organized medicine, consequently many members probably feel that the primary function in attending meetings is for information only. This they can read in published form. Furthermore, the long work week of the average physician in private practice contitutes a barrier to other activity. This is well reflected by the fact that while general practitioners make up a good share of the Association membership, the delegates are overwhelmingly specialists. In 1960, for example, forty per cent of the physicians in private practice were general practitioners, but eighty per cent of the membership of the House of Delegates were specialists.[73] It is estimated that over ninety per cent of the Association officers are specialists. Specialists, naturally, are better able to devote time to the service of the profession, but their preponderance in leadership roles does not encourage grass-root participation.

The leadership of the Association frequently assert that their association reflects the voice of organized medicine. Despite the fact that a sizable number of physicians are not members, the lack of participation of members themselves, and conflicts with other organizations involved with health care--the Association is supported by the majority of the profession. Garceau has suggested that the inertia of the majority of members may be attributed to the consuming nature of medicine, the drive toward material success, and an aversion against politics.[74] Consequently, the members turn to the Association to do their thinking and fighting for them. Although democracy is lacking in the internal structure of

the Association, it does represent the internal harmony which is maintained.[75]

The participation of the members of the American Library Association in their organization is somewhat easier to discuss than the similar matter with the Medical Association. Since only a national association is involved, and not state or local bodies, participation is more readily identified. It cannot be said that the 32,000 personal members of the Association are involved in activities of library associations below the national level, though it seems likely that a good proportion of them do so participate and have been officers of regional, state, local, and specialist units.

Participation on the national level consists of being an officer or the member of a committee of the Association or one of its constituent divisions or organizations, of which there appear to be little lack. With support of the national professional association placed largely on a voluntary level, one usually has to have some interest, however weak it may be, in the furtherance of libraries in the country.[76] Local issues and pressure do not compel membership!

With the membership thus selected to begin with, virtually all the members of the Association's Council are elected directly by the membership, either at large or by constituent organization or chapter. Thus, in the election of the governing assembly of the Association, the membership may participate freely. The officers, too, of the Association are elected by the membership at large. In the election of officials, therefore, the Association required membership participation.

Within the organization, the Association has striven to provide as much democracy as possible in a large professional association with many variant interests represented. This has resulted in continuous soul-searching for better

organization to reach its goals and a fierce pride in its democratic processes.[77] By diversified agencies under its aegis, the American Library Association has attempted to provide a home for all segments of the profession, each with a multiplicity of offices and positions to be filled, creating the illusion of democratic participation on the part of the members.[78] But even the activity of the hundreds of officers, many members feel entirely untouched by the national organization. The suggestion has been made that the association is too large to continue the semblance of mass participation. The democracy is primarily a form and not a reality. Yet the possibility of any member participating in the Association is a closely guarded privilege that will be given up only after considerable struggle, even though the ability to act quickly and efficiently in concerted axtion may be sacrificed.

The contrast between physicians and librarians in their respective professional associations is apparent from this review.

The role of the leadership is tied closely to membership participation. The problem of oligarchical control is common for large professional associations. How the organizations under study have reacted to this problem will now be discussed.

The tight control of the structure of the American Medical Association by the House of Delegates has been described in some detail above. The delegates serve two-year terms and the Trustees serve five-year terms. The Trustees have far-reaching powers and although nominally responsible to the House of Delegates, the Board functions in effect in the typical role of corporate directors.[79] Furthermore, the House of Delegates and the Board of Trustees appoint the chairmen and members of the several councils and standing committees of the Association under their respective jurisdictions. This power provides for the continuity of leadership and points of view.[80] One aberration from this plan of appointment is

the election of officers of the speciality sections of the Scientific Assembly. Specializations, including general practice, govern themselves but still have only one delegate each to the House of Delegates.

The manipulation by the leadership of the Association of the powers by appointment keep the unity of the Association intact.[81] Factions are not allowed to develop within the organization. Once forced to operate outside of the Association, dissident forces are usually at a loss to fight the mammoth force of organized medicine.

During the critical period of the nineteen thirties and forties, the Association was personified by Morris Fishbein, who was editor of the Journal from 1924 until 1949. His activities on behalf of the Association went far beyond the editorship, an important enough post for formulating opinion. His energy, however, alienated groups within and without the profession and the Trustees were forced by the membership to plan for his retirement.[82] Fishbein's power is the closest approach to one-man rule or authority that the Association has known in recent years. The control exerted by Fishbein over the Association caused some members to reflect on the quality of their professional stance.[83] Dependence upon others to do the acting for the profession had serious drawbacks. Perhaps the illustration will be sufficient to prevent such manipulation from occuring again so baldly. The lack of dissent media for the profession must be noted.[84] By exercising tight control over the Association's general publications, points of view in opposition to the official policies are not heard. The position of editor is not a minor one.

One may say, then, that the oligarchical control of the Association is not a questionable matter; it is fact. Members certainly know this and may be dissatisfied at times because of it, but in the end they stand to gain more by

perpetuating the present system than by trying to oppose it or change it. The unity of the profession is one of the most important beliefs in the professional image of organized medicine.

The role of the association administrator varies in the two organizations under study.[85] His duties are to expedite the work of the association and this work is as different as the organizational structure of the associations. In the American Medical Association his role is that of a business manager primarily; he runs the main headquarters building and is responsible for technical details. In the American Library Association, the administrator has taken on different responsiblities at different times. However, for some years he has been the one continuing figure in the Association when others come and go. Much of the public relations and communication of the Association is done through him.

The role of the leadership in the American Library Association has varied over time with the kind of organization employed. In the early years, as with the Medical Association, individual leaders took much of the initiative and performed most of the official functions. As the organization grew, the power of the headquarters staff increased. Since the officers served for short terms, the administrative staff of the headquarters assumed greater importance. After 1940 the divisions became more autonomous and the Council took on greater significance. With the reorganization of 1956, the Council became the legislative body and the Executive Board became responsible to the Council, instead of being elected by the membership at large.

Critics within the Association have charged that the elected leadership includes the same few people year after year. This charge was made even after the restructuring of the nineteen fifties which was to make the Association more

democratically organized and responsive to member wishes.[86] It is probably inevitable that the elected leadership also includes more administrators than general librarians. This fact may reflect the judgment that the Association is more concerned with libraries, and thus administrators, than with librerians.[87]

Since the emphasis on diversity is so great and the prerogatives of different interests is jealously guarded by divisions, round tables, and committees, the role of the central headquarters becomes the only single unifying force in the Association. The Executive Director and his staff help to maintain the continuity of the organization in conjunction with the Executive Board and the Council. As suggested above, the headquarters staff plays a much greater role in the leadership of the American Library Association than does the administrative arm of the American Medical Association. In the eyes of the general member, administrative matters seem to consume a great amount of the Association's time. This fact has been cited by those who favor a more decentralized federation of special type-of-library associations.

Although some members of the profession have been reluctant to relinquish any of their "power" to a central headquarters staff, the staff has exerted more influence on the Association as a whole than either the Council or the Executive Board. The tenure of Carl Milam as Executive Secretary from 1920 to 1948 was perhaps the high point in the power of the central headquarters.[88] As his term lengthened in the crucial period of growth for the profession, his influence increased and it seemed to some that he was building an inner clique around him. With his departure in 1949, the membership hoped that the staff might be again primarily responsive to its needs.

The profession of librarianship does not seem to feel the unity in public objectives that organized medicine does. It has established checks and balances

in order that the governing boards "are kept in a position of responsibility and accountability."[89] The leadership, both elected and appointed, seems to be aware of the charge of oligarchical control by some of the members, and is attempting to be responsive to the membership or at least, to lessen some of the conflicts.

The matter of segmentation within the professions under study is the third matter to be discussed. One of the evidences of a growing profession is specialization. When a field of knowledge or activity increases to the extent that one person cannot master well the whole body of information or technique, the profession splits into specializations.[90] In medicine this trend began very early, as professions stand, and it has gone the furthest.

Organized medicine has carried with it the tension between unity and diversity for a long time. In the early years the unity was important in eliminating the competition of other medical organizations, most of which the Association labelled "sectarian." However, in the 1901 constitution, provision was made for thirteen specialty sections within the Association to which interested physicians could belong. This number has now been increased to twenty-seven, at least ten of which publish regular journals. The largest registration at annual conventions has been sections on general surgery, general practice, and internal medicine.

Specialty Boards have been established

> (a) to assist in improving the quality of graduate education in that field, (b) to establish minimum education and training standards in the specialty, in conformity with general provisions, (c) to determine whether candidates have received adequate preparation as defined by the Board, (d) to provide comprehensive examinations to determine the ability and fitness of such candidates and (e) to certify the competence of those physicians who have satisfied the requirements of the Board, as protection to the public and profession.[91]

At present there are nineteen such boards, which are approved by the American Medical Association and the Advisory Board for Medical Specialties. This

apparatus provides a means of recognizing the special interests of segments of the profession and gives them certain power in establishing and enforcing tandards.

The existence of the many national scientific medical societies is recognized and their special functions are noted by official approval of the Association and listing in the American Medica Directory. The more than eighty-seven organizations recognized in this way must meet six criteria:

1. The society must be a scientific society with at least 66 per cent of its active membership holding an M.D. degree.
2. The society must be national in scope. If it has active members in 50 per cent or more of the states, it will be considered national in scope.
3. The society must have been in existence for at least five years.
4. The society must be active and hold at least one meeting a year.
5. A new society wishing to have its membership recognized by the A.M.A. must submit a resolution showing that the listing has been requested and approved by the governing body of the organization.
6. If international, the society must have a United States branch or chapter, and this chapter must meet all of the above named rules.[92]

These associations include a wide variety of specializations and have their own organization with officers, financial support, and publications. Yet they are related to the American Medical Association, because almost all of their members are also Association members. This arrangement takes much of the burden of concern for specialization from the shoulders of the Association and the state associations and also allows for the autonomy of special group interests.

Sociologists have noted that there is danger of thinking of a profession as a homogeneous entity because of the many interests and segments that are hidden behind apparent unity.[93] Yet, for all the diversity, unity is the great goal of the national Association. Norman A. Welch, in his inaugural speech as incoming President of the Association in 1964, pointed out the essential nature of unity in the medical profession.[94] Admitting that specialized groups and geographical units had drained some of the leadership from the Association, Welch

affirmed that medicine consisted not alone in science, but also in the art and the socio-economic political aspects of medical practice. He suggested that the medical profession needed to be unified in the latter sphere. In other countries the profession has been divided and conquered, usually by the government. "We must not let this happen in the United States of America," he pleaded.

The American Medical Association seems to have dealt well with the problem of segmentation by recognizing new interests without getting involved directly in them and by concentrating as a national body on issues upon which most physicians can agree.

Segmentation within the library field has been dealt with differently. In the ninteenth century sections for librarians in specialized types of libraries were formed within the American Library Association. These grew in number and importance, until in 1940 they were made divisions with semi-autonomy. Some of these special groups, such as the Association of College and Reference (later Research) Libraries, have included members who felt that the interests of the special associations were not being served by organizing under the Association with its emphasis on general library service in public libraries.[95] The functioning of the fourteen divisions is one reflection of the specialization within the Association.

Other special interest groups of librarians have formed their own associations outside the umbrella of the Association, but they have maintained an affiliation with the national association. The Association is authorized to affiliate with it any "national or international organization having purposes similar to those of the Association."[96] Eleven such associations enjoy this status, including the Medical Library Association and the American Association of Law Libraries, both of which also maintain ties with their repective national

professional associations. The criteria for accepting organizations and maintaining control over them is not stringent.

Several important segments of the library profession have found that their best interests are served by retaining their complete independence from the Association. One of the most influential groups in this category is the Special Libraries Association. These groups have not felt compulsion to affiliate with the Association in order to fulfill their purposes.

Thus one can see that the profession is seriously segmented into various groups working with different kinds of materials in different kinds of libraries. The weak Council of National Library Associations is the only semblance of unity in the profession, even though the American Library Association is the giant among the member organizations. The Library Association has not been able to bring together the various segments of the profession and concentrate on issues of common concern for all librarians. This is a serious limitation on the effectiveness of the national organization. The situation probably results from the fact that the Association has little identification apart from its constituent segments, each of which has its own work to do. There is little unity of purpose or goals. The breadth and variety of membership interests in this general association may be one of the causes of the lack of unity.

From time to time a restructuring of the Association has been proposed; the last serious proposal was made in 1961.[97] The proposal was that the Association become simply a federation of constituent societies and serve as a clearing house and as a focus for political action and support of general professional goals. Such a federation, making the Association more similar to the position of the American Medical Association in the medical profession, might provide a route through which all librarians could join to support general goals. To date,

however, the problem of segmentation in the profession has not been met successfully.

VII.

The preceding discussion has made several points clear. The two associations under consideration have through their organizational structures had an effect, either positive or negative, upon their professions and upon the society in which the professions exist. The character of the professions, in turn, has shaped the nature of the organizational structure. Gilb suggests three stages of development of professionals. First,decisions are made by the elite of the profession; then sometime afterward, the profession enters a period of forceful articulation of various interest groups within the profession; finally, the profession enters a period of integrated differentiation in which the identity of special interest is maintained in the midst of a concensus developed to gain political and economic advantages.[98] If this hypothesis is true,. then the early decisions of professional leaders do affect the course of the profession. That course, as reflected in organizational structure, may be a primary force in the development of the profession, both in the eyes of its practitioners and in the opinion of society.

With regard to the medical profession, the American Medical Association has from its inception emphasized the unity of the profession; all other issues took second place. In order to achieve this unity and to provide a basis for concerted effort, central authority has been fostered and been maintained. The Association has limited its official concerns to issues which affect all physicians; other matters have been left to local and state societies through decentralized delegation of authority and power. The Association has stressed many objectives and has brought about apparent unity in the striving for these goals.

The American Library Association, on the other hand, almost from the beginning has stressed the diversity of its members and has made provision for this diversity in the governance of the Association. The high regard for democratic processes has brought the Association to the position of being a forum for discussion of various issues within the profession.[99] Instead of leaving the diversity for other channels to deal with, the Association has concerned itself with trying to incorporate all interests. The result has been that the comparatively modest aims of the Association have not been achieved. The profession has not enjoyed unity and the benefits of a strong association working for benefits applicable to all practitioners.

In its dealing with society the American Medical Association since the early days of this century has assumed public respect and trust and has acted to reinforce and to justify this attitude. It has claimed, and has been largely successful in maintaining, that it as the voice of the medical profession has the sole competence to make decisions on medical matters. In gealously guarding this prerogative, it has protected itself and has affected society for its advantage.[100]

The American Library Association does not enjoy the unified support of the librarians in the country. Neither can it claim sole competence to deal with the promotion of books and libraries. Other agencies are active in this broad theater of interest. If the Association were to confine itself to, or emphasize, professional matters of concern to the practitioners and display this activity in an attempt to influence the public image of the librarian, then the Association would begin to act as a bona fide professional organization. Instead, it seems to be concerned with the artifact and the dispensary, books and libraries. The American Medical Association would be less influential if it confined its

activities to promoting drugs and hospitals!

The nature of the profession, then, and the status accorded by society have acted to effect the organizational structure of the profession. The structure provides an indication of the profession's view of itself and in its public expression, the structure effects the image of the profession within the culture.

Predictions cannot be made with any precision from a review of this nature. However, trends may be discernible. If the membership of the American Medical Association continues to decline, due to the increase of specialization and group practice and the growth of institutional employment of physicians, the Association may need to modify its creed of strict adherence to practices and policies favoring the general practitioner. The strong emphasis on individualism may have to be balanced by the achievement of benefits that will appeal to the growing number of physicians whose needs are not being met by the Association.

The American Library Association is also faced with a decision to enter the arena of institutional involvement for the benefit of individual librarians.[101] If organized medicine has been protective of the individual physician, "organized librarianship" has been involved with institutional programs almost exclusively. The American Library Association will need to prove its practical value to its own practitioners by acting, perhaps as a professional bargaining agent, in the institutional or governmental setting. Both Associations will need to face the issue of practical relevance to its members and potential members.

VIII.

In summary and conclusion, the American Medical Association has been a medium through which the goals of the profession have been voiced. These goals have shaped the organizational structure which has enabled the profession to deal

successfully with the three problem areas discussed above. The Association enjoys the support, if not the participation, of the majority of the profession. Its leadership has been strong and active, deriving its authority from indirectly elected representatives. The segments of the profession have been allowed to develop and essential unity has been preserved.

The American Library Association has not focused on clearly defined goals, and the organizational structure has not encouraged concerted action toward professional objectives. The three problem areas have been met with varying success. The Association does not have the support of a majority of the profession, but members have ample opportunity for activity. The leadership is drawn from the profession but does not in practice exercise the authority to commit the profession to action. The segments within the profession are allowed to fragment the organization and dilute the force which the Association might bring to bear on common problems. The three problem areas with which the Association must grapple remain for solution.

A great deal of information and insight into the composition of professions may be gained by a careful examination and analysis of their developing organizational structures. This essay has attempted to provide the beginning of such a study of the American Medical Association and the American Library Association.

APPENDICES

Number of Physicians/Surgeons and Librarians in the United States and in the American Medical Association and American Library Association

American Medical Association: Organization Chart

American Library Association: Organization Chart

American Medical Association Purposes & Responsibilities and Standing Committees

American Library Association Divisions and Round Tables

American Medical Association Balance Sheet, December 31, 1967

American Library Association Balance Sheet, August 31, 1968

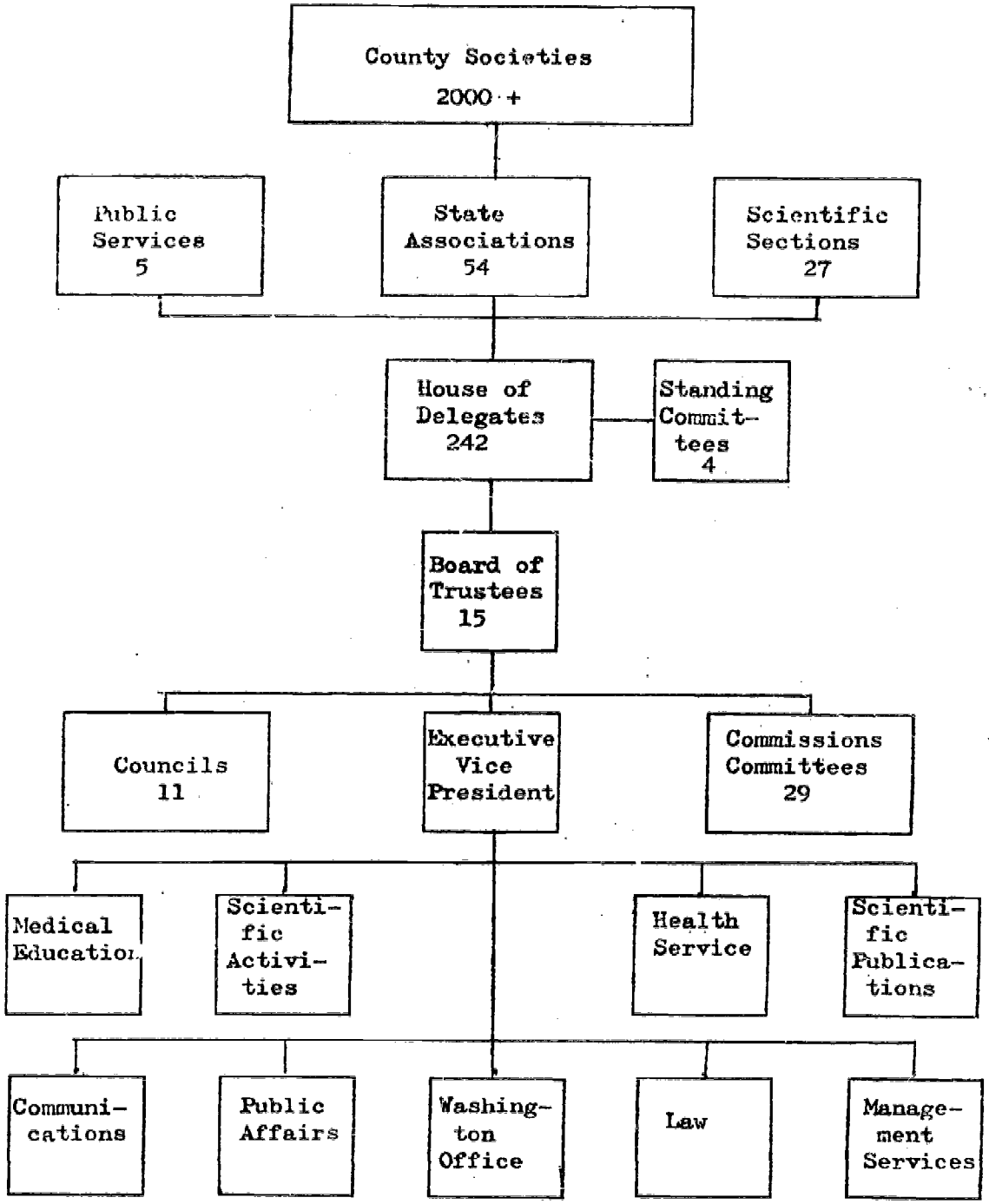
NUMBER OF PHYSICIANS/SURGEONS AND LIBRARIANS IN THE UNITED STATES
AND IN THE
AMERICAN MEDICAL ASSOCIATION AND AMERICAN LIBRARY ASSOCIATION

	Physicians/Surgeons			Librarians		
Year	U.S.	A.M.A.	%	U.S.	A.L.A.	%
1890	105,000*	5,000x	5		290	
1900	132,000*	8,000	6	4,000*	874	22
1910	151,000*	70,000	46	7,000*	2,000	29
1920	145,000	83,000	57	15,000*	4,000	27
1930	153,000	98,000	64	30,000*	13,000	43
1940	174,000	116,000	67	36,000*	15,000	42
1950	195,000	148,000	76	49,000	20,000	41
1960	245,000	179,000	73	61,000	25,000	41
1968	317,000	209,000	65	95,000+	39,000	41

Source: Official figures and estimates from each Association journal, rounded off to the nearest thousand. Exceptions:
* U.S. Census data
x Estimate from 1891 figure
+ Estimate based on library school graduates and placement figures
Notes: Until 1920, Osteopaths are included in U.S. Census figures. 1910 figure for librarians does not include catalogers. Figures for A.L.A. include institutional members, 6,473 in 1968.

AMERICAN MEDICAL ASSOCIATION

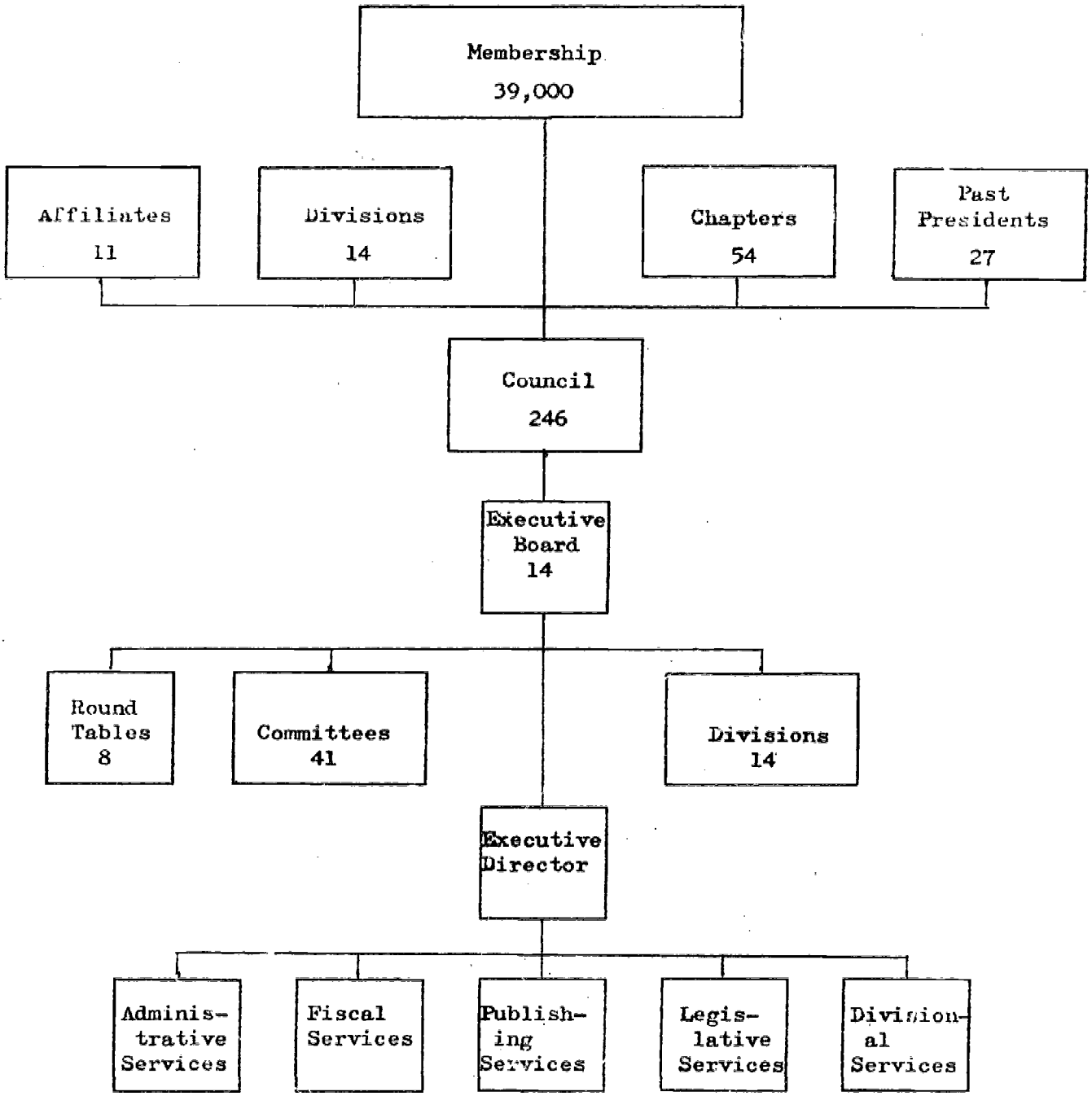
Organization Chart



The figures represent the number of units in each category. This simplified chart focuses on the composition and responsibilities of the House of Delegates.

AMERICAN LIBRARY ASSOCIATION

Organization Chart



The figures represent the number of units in each category. This simplified chart focuses on the composition and responsibilities of the Council.

AMERICAN MEDICAL ASSOCIATION

Purposes & Responsibilities

It is the responsibility of the American Medical Association, as the representative of the American medical profession, to continue to foster the advancement of medical science and the health of the American people.

Its continuing purposes are to meet this responsibility through the following means:

1. By encouraging the further development of medical knowledge, skills, techniques and drugs; and by maintaining the highest standards of practice and health care.

2. By creating incentives to attract increasing numbers of capable people into medicine and the other health-care professions.

3. By advancing and expanding the education of physicians and other groups in the health-care field.

4. By motivating skilled physicians who have the art of teaching to apply themselves to developing new generations of excellent practitioners.

5. By fostering programs that will encourage medical and health personnel to serve voluntarily in the areas of need for medical care.

6. By developing techniques and practices that will moderate the costs of good medical and health care.

7. By seeking out and fostering means of making all health-care facilities—physicians' offices, hospitals laboratories, clinics and others—as efficient and economical as good medical practice and attention to human values will permit.

8. By combining the utilization of the latest knowledge for prevention and treatment with the vital healing force of the physician's personal knowledge of and devotion to his patient.

9. By maintaining the impetus of dedicated men and women in providing excellent health care by preserving the incentives and effectiveness of unshackled medical practice.

10. By maintaining the highest level of ethics and professional standards among all members of the medical profession.

11. By continuing to provide leadership and guidance to the ... medical profession of the world in meeting the health needs of changing populations.

STANDING COMMITTEES

HOUSE OF DELEGATES

Council on Constitution and Bylaws
Judicial Council
Council on Medical Education
Council on Medical Service

BOARD OF TRUSTEES

Council on Drugs
Council on Environmental and Public Health
Council on Foods and Nutrition
Council on Health Manpower
Council on Legislative Activities
Council on Mental Health
Council on National Security
Council on Occupational Health
Council on Rural Health
Council on Scientific Assembly
Council on Voluntary Health Agencies

AMERICAN LIBRARY ASSOCIATION

DIVISIONS

Type-of-Library

American Association of School Librarians
American Association of State Libraries
Association of College and Research Libraries
Association of Hospital and Institution Libraries
Public Library Association

Type-of-Activity

Adult Services
American Library Trustee Association
Children's Services
Information Science and Automation
Library Administration
Library Education
Reference Services
Resources and Technical Services
Young Adult Services

ROUND TABLES

Exhibits
International Relations
Junior Members
Library Service to the Blind
Staff Organizations Associate
American Library History
Library Research

AMERICAN MEDICAL ASSOCIATION

Assets

Current Assets		
Cash	2,794,108.68	
Notes & Accounts Receivable	1,350,450.59	
Inventories	1,350,946.52	
Total Current Assets		5,495,505.79
Deferred Charges		
Deposits	112,233.75	
Prepaid Expenses	309,941.27	
Total Deferred Charges		422,175.02
Fixed Assets		
Land	1,126,047.14	
Building less Accumulated Depreciation	7,234,976.95	
Furniture & Equipment less Accumulated Depreciation	899,785.08	
Total Fixed Assets		9,260,809.17
Investment-Securities		
U.S. Government Securities	1,138,935.96	
Common Stock	5,895,427.22	
Total Investment-Securities		7,034,363.18
Other Assets		1,310,715.99
Total Assets		23,523,569.15

Liabilities and Reserves

Current Liabilities		
Accounts Payable	1,618,743.03	
Accrued Taxes	293,311.91	
Total Current Liabilities		1,912,054.94
Deferred Income		
Dues & Subscriptions		2,599,903.96
Total Liabilities		4,511,958.90
Reserves		
Reserves for Replacement of Building and Equipment	15,894,766.81	
Reserves to finance anticipated needs in the future	3,116,843.44	
Total Reserves		19,011,610.25
Total Liabilities & Reserves		23,523,569.15

AMERICAN LIBRARY ASSOCIATION

Treasurer's Report

Balance Sheet—August 31, 1968

Assets

ENDOWMENT FUNDS			
Cash in agency account		$ 28,437.54	
Investments—at cost		2,196,003.85	
Real Estate		1,030,174.30	
Accounts Receivable—ALA		913,714.38	
TOTAL ENDOWMENT FUND ASSETS			$4,168,330.07
GENERAL AND SPECIAL FUNDS			
Cash in banks		134,237.91	
Cash on hand		500.00	
Cash on deposit		425.00	
United States treasury bills		490,165.00	
Certificates of deposit		500,000.00	
Accounts receivable—commercial		283,315.38	
—miscellaneous		6,841.76	
Advances to officers and staff members		6,984.61	
Prepaid expenses		7,918.47	
Deferred charges		11,473.51	
Office devices and building equipment			
Less accumulated depreciation to date of $36,449.05		60,668.51	
Inventory of postage, paper, and supplies		66,481.88	
Headquarters building—construction, equipment, and other costs	$1,358,074.36		
Less—return to endowment including depreciation of $115,157.82	305,735.01	1,052,339.35	
Headquarters building remodeling		128,316.31	2,749,667.69
TOTAL ASSETS			$6,917,997.76

Liabilities

ENDOWMENT FUND BALANCES		
Carnegie Fund	158,696.53	
Carnegie Corporation Endowment Fund	3,589,631.33	
General Endowment Fund	324,517.76	
ALTA Endowment	14,700.00	
Sarah C. N. Bogle Endowment Fund	5,018.90	
Melvil Dewey Medal Fund	501.69	
Frederic G. Melcher Scholarship Fund	58,648.83	
Oberly Memorial Fund	1,078.64	
Herbert Putnam Honor Fund	2,482.51	
James L. Whitney Fund	13,053.88	
TOTAL ENDOWMENT FUND LIABILITIES		4,168,330.07
GENERAL AND SPECIAL FUNDS		
Endowment Fund Payable	913,714.38	
Miscellaneous accounts payable	49,053.76	
Deferred income	7,268.68	
General and Special Fund Balances	1,779,630.87	2,749,667.69
TOTAL LIABILITIES		$6,917,997.76

BIBLIOGRAPHICAL NOTES

[1]Lee Taylor, Occupational Sociology (New York, 1968), p. 361. Taylor devotes a chapter to "Associations and Societies."

[2]Gilda Nimer, Professions and Professionalism: A Bibliographic Overview (Manpower Research Project Newsletter: School of Library and Information Services, University of Maryland. Issue no. 2, July 1968), p. 1.

[3]Taylor, Occupational Sociology, p. 344; J. O. Hertzler, American Social Institutions: A Sociological Analysis (Boston, 1961), p. 313, states, "The members of the different professions are usually organized into associations of their own, not only to maintain the organizational regulations, but also to preserve and enhance their activities in society."

[4]Hertzler, American Social Institutions, p. 313.

[5]This definition was derived from the description of "physician" in The American College Dictionary (New York, 1956), p. 914 and the criteria for inclusion in the American Medical Directory, 22nd ed. (Chicago, 1963).

[6]This definition was derived from the description of "librarian" in The American College Dictionary (New York, 1956), p. 703 and the operational definition used by The Bowker Annual of Library and Book Trade Information, 1968 (New York, 1968), p. 313. Statistics are compiled biennially in U.S. Office of Education, Digest of Educational Statistics. Public and nonpublic elementary and secondary school librarians are included in this definition is they have taken 15 units or more of library science courses.

[7]Peter M. Blau and W. Richard Scott, Formal Organizations: A Comparative Approach (San Francisco, 1962), pp. 45-49, "Mutual-Benefit Associations."

[8]Rue Bucher and Anselm Strauss, "Professions in Process," American Journal of Sociology, LXVI (January 1961), 325-334, reprinted as "Professional Associations and the Process of Segmentation" in Howard M. Vollmer and Donald L. Mills (eds.), Professionalization (Englewood Cliffs, N.J., 1966), pp. 185-196.

[9]James G. Burrow, AMA: Voice of American Medicine (Baltimore, 1963). Unless otherwise specifically noted, historical data about the American Medical Association is drawn from this source.

[10]Hertzler, American Social Institutions, p. 313, has stated the following. "The actual process of professionalization involves, among several key features, two in particular: (1) the establishment and maintenance of high minimum qualifications and requirements in the way of special knowledge and practical and technical proficiency; and (2) the establishment and maintenance of high ethical standards governing the practice of the profession and the relationships of the practitioners with others."

[11]Burrow, AMA, p. 10.

[12]Burrow, AMA, p. 15.

[13]The constitution of 1901 is found in Journal of the American Medical Association, XXXVI (June 8, 1901), 1643-1648. "The object of this Association shall be to federate into one compact organization the medical profession of the United States, for the purpose of fostering the growth and diffusion of medical knowledge, of promoting friendly intercourse among American physicians, of safeguarding the material interests of the medical profession, of elevating the standard of medical education, of securing the enactment and enforcement of medical laws, of enlightening and directing public opinion in regard to the broad problems of state medicine, and of representing to the world the practical accomplishments of scientific medicine."

[14]Morris Fishbein, A History of the American Medical Association, 1857-1947 (Chicago, 1947), pp. 887-899.

[15]Abraham Flexner, Medical Education in the United States and Canada (Boston, 1910).

[16]Burrow, AMA, p. 49.

[17]Burrow, AMA, p. 153.

[18]The "Position of the American Medical Association in 1934 on Voluntary Health Insurance Plans" is included in Burrow, AMA, pp. 236-237. The ten-point position indicates the argument of the Association. The first and last points were: "1. All features of medical service in any method of medical practice should be under the control of the medical profession. No other body or individual is legally or educationally equipped to exercise such control. . . . 10. There should be no restriction on treatment or prescribing not formulated and enforced by the organized medical profession."

[19]This campaign is covered in quite detail by Burrow, AMA, pp. 354-385, in a chapter entitled, "The AMA at Armageddon."

[20]"A.M.A. Membership," JAMA, CLXVI (March 8, 1958), 1263.

[21]Elton Rayack, Professional Power and American Medicine (Cleveland, 1967), pp 10-12.

[22]See organization chart included in the appendices.

[23]Information for the organizational structure of the Association was drawn from the following sources. "Constitution," JAMA, XXXVI (June 8, 1901), 1643-1648; "Official Call," JAMA, CCII (October 23, 1967), 312-322; David R. Hyde and Payson Wolff, "The American Medical Association: Power, Purpose, and Politics in Organized Medicine," Yale Law Review, LXIII (May 1954), 942-944.

[24]The Association attempted to standardize the various types of memberships in the early nineteen fifties. "Development of Uniformity in Membership Regulations Between Constituent Associations and the A.M.A.," JAMA, CLIII (November, 28, 1953), 1179-1181.

[25]See organization chart included in the appendices.

[26]American Medical Directory, 22nd ed. (1963), p. x.

[27]Only four of the speciality groups existed before 1933. Fishbein, History, p. 906.

[28]See list of purposes and responsibilities included in the appendices.

[29]George B. Utley, Fifty Years of the American Library Association (Chicago, 1926). Unless otherwise specifically noted, historical data about the American Library Association during this period is drawn from this source.

[30]As quoted in "American Library Association Management Survey," ALA Bulletin, XLIX (September 1955), 417.

[31]ALA Bulletin, LXII (November 1968), 1263, 1265.

[32]David H. Clift, "Associations in the United States," Library Trends, III (January 1955), 221-237, summarizes the reorganization efforts to date. These are also reviewed in Cresap, McCormick and Paget "American Library Association Management Survey," ALA Bulletin, XLIX (September 1955), 411-464. Unless otherwise specifically noted, information on reorganization activities is drawn from these sources.

[33]Oliver Garceau, The Public Library in the Political Process (New York, 1949), pp. 155-156. Although now dated, Garceau has an interesting chapter on "Professional Association," pp. 152-200, which examines the structural problems of the Association.

[34]Garceau, Public Library, p. 170. The role of personalities is discussed.

[35]"American Library Association Management Survey," p. 421.

[36]"American Library Association Management Survey," pp. 430-434.

[37]"American Library Association Management Survey," p. 448.

[38]See organizational chart included in the appendices.

[39]ALA Bulletin, LXII (November 1968). The constitution and by-laws, as well as the directory, of the Association is included in this issue, an annual compilation of "organization and information." Data about the organizational structure of the American Library Association is drawn from this source.

[40]Hyde and Wolff, "American Medical Association," p. 944.

[41]Oliver Garceau, The Political Life of the American Medical Association (Cambridge, Mass., 1941) is the classic work on the subject even though it is nearly thirty years old. His chapter, "Political Physiology: The Process of Governing in the Association" (pp. 68-129), deals in detail with policy

formation and electoral processes of the House of De egates, the nature of Association officials, local society politics, the molding of medical opinion and authority, and relations between societies.

[42]C. James F. Parsons, "Can the AMA be made an Effective Political Instrument," Medical Economics, XXI (May 1944), 47. Parsons is disturbed over the fact that lack of opportunity for dissent has taken the Association away from an interest in the opinions of members.

[43]Rayack, Professional Power, p. 4.

[44]See Hyde and Wolff, "American Medical Association," pp. 947-953. There is some evidence that the Association speaks for a diminishing number of the profession after 1950. See table of membership included in the appendices.

[45]Rayack, Professional Power, pp. 7-10.

[46]Garceau, Public Library, pp. 195-197, suggests a stronger relationship between the national and the state associations.

[47]ALA Bulletin, LXII (November 1968), 1265.

[48]David H. Clift, "The Role of Library Associations: A Symposium--The Association's Viewpoint," Medical Library Association. Bulletin, LI (January 1963), 45. In discussing the Association's tax-exempt status, Clift says, "While this status permits the association to do a number of things and receive a variety of benefits, it may also deny the association the right to carry on certain activities chiefly those that may result in direct economic benefits to the members and which are not educational in nature, as, for example, the conducting of a placement service." He continues: "The broad objectives of a library association are the furthering of library service, the profession of librarianship, and the social and cultural welfare of the country. The last named is in the long run the most important; the first two, in fact, are important only to the extent that they contribute to it."

[49]Robert P. Haro, "Overdue: Professional Pursuits," Wilson Library Bulletin, XLIII (February 1969), 461, 480.

[50]Hyde and Wolff, "American Medical Association," pp. 953-954.

[51]JAMA, CXCVI (April 11, 1966), 10.

[52]"A.M.A. Membership," JAMA, CLXVI (March 8, 1958), 1263.

[53]ALA Bulletin, LXII (November 1968), 1265-1267.

[54]The figures for the calendar year 1961 reached about $17.5 million. JAMA CLXXX (May 19, 1962), 566. Rayack, Professional Power, p. 10, estimated the figure to be $23 million in 1964. Hence the current estimate. The American Library Association figures are given for the fiscal year in ALA Bulletin, LXII (December 1968), 1399-1405.

[55]JAMA, CCV (September 2, 1968), 9 and ALA Bulletin, LXII (December 1968), 1404-1405.

[56]American Medical Association, Annual Report, 1968 and ALA Bulletin, LXII (December, 1968), 1399. See reproduced balance sheets included in the appendices.

[57]American Medical Association, Annual Report, 1968 and ALA Bulletin, LXII (December 1968), 1401-1403.

[58]The political aspects of association organization are the focus of the work of Oliver Garceau in The Political Life of the American Medical Association (1941) and The Public Library in the Political Process (1949).

[59]Hyde and Wolff, "American Medical Association," pp. 954-959.

[60]Garceau, Political Life, pp. 165-168, admits "The AMA has done some things exceedingly well and some very badly." He studies the role of organized medicine in external politics in his chapter entitled, "Political Ecology: Group and Community" (pp. 165-175).

[61]Parsons, "Can the AMA be made an Effective Political Instrument," pp. 44-47, 114.

[62]Burrow, AMA, p. 362.

[63]Rayack, Professional Power, p. 11.

[64]Hyde and Wolff, "American Medical Association," p. 959.

[65]Paul Howard, "Associations and United States Legislation," Library Trends, III (January 1955), 279-289 provides a good summary to the date of publication. The motivations are suggested on page 279.

[66]Garceau, Public Library, pp. 177-187. U.S. government assistance was sought for extension of services and demonstration projects.

[67]Garceau, Public Library, pp. 134-135.

[68]See table of membership included in the appendices.

[69]Hyde and Wolff, "American Medical Association," pp. 941-942.

[70]Rayack, Professional Power, p. 2.

[71]Andrew S. Markovits, "Let's Kill Autocracy in Medicine!" Medical Economics, XL (February 11, 1963), 122-124.

[72]As quoted in Rayack, Professional Power, p. 14.

[73]Rayack, Professional Power, p. 14.

[74]Garceau, Political Life, pp. 61-63, 101.

[75]Herbert H. Kaufman, "Does the A.M.A. Heed Our Views?" Medical Economics, XXXVIII (June 5, 1961), 76-84.

[76]Since membership is often a nominal thing to the librarian who joins, the inactive majority of the profession is more apparent than the active minority.

[77]David H. Clift, "Discussion," to Ralph E. Ellsworth, "Critique of Library Associations in America," Library Quarterly, XXXI (October 1961), 397.

[78]Eli M. Obler, "A Constitutional Crisis in the ALA?" ALA Bulletin, LX (April 1966), 385.

[79]Rayack, Professional Power, p. 3.

[80]The leadership of the American Medical Association is considered by Oliver Garceau in his Political Life, pp. 30-67. The chapter, entitled "Political Histology: The 'Active Minority'," includes discussion on the where, the who, and the why of established leadership. Though published in 1941, it is still useful.

[81]Garceau, Political Life, p. 23.

[82]Burrow, AMA, pp. 373-374.

[83]Parsons, "Can the AMA be made an Effective Political Instrument?" p. 45.

[84]Hyde and Wolff, "American Medical Association," p. 948 and Rayack, Professional Power, p. 13.

[85]Vance E. Lockhart, "Associations: Their Function and Structure," Drexel Library Quarterly, III (July 1967), 254. "The job of the association administrator is to unleash the power of the members, and through the effective use of resources to provide the harness in which the members can work together productively. Only when this is done can the members of voluntary associations contribute to their fullest, and only then will the investment of time and energy be meaningful."

[86]Obler, "Constitutional Crisis," p. 385.

[87]Haro, "Overdue," pp. 461, 480.

[88]Garceau, Public Library, pp. 168, 170-171. Here is an analytical discussion of the role of the headquarters staff and the Executive Secretary (now Director).

[89]Clift, "Role of Library Associations," p. 49.

[90]Corinne L. Gilb, Hidden Hierarchies: The Professions and Government (New York, 1966), p. 83.

[91]American Medical Directory, 22nd ed. (1963), p. x.

[92]American Medical Directory, 22nd ed. (1963), p. xiii.

[93]Bucher and Strauss, "Professional Associations," p. 186.

[94]Norman A. Welch, "Unity in Medicine," JAMA, CIXC (July 20, 1964), 223-225.

[95]Ralph E. Ellsworth, "Critique of Library Associations in America," Library Quarterly, XXXI (October 1961), 382-400.

[96]ALA Bulletin, LXII (November 1968). 1264.

[97]Ellsworth, "Library Associations," pp. 393-395; Eli M. Obler, "Library Associations: Their History and Influence," Drexel Library Quarterly, III (July 1967), 260-261.

[98]Gilb, Hidden Hierarchies, 157-178. With regard to the status of the two Associations in the three-stage Gilb hypothesis, the decisions of the professional elites began to be made at the founding dates. The American Medical Association possibly reached the second state, articulation of interests, about 1910 and the third state, integrated differentiation, about 1945. The American Library Association possibly reached the first stage about 1939. The third stage has not been reached.

[99]Clift, "Role of Library Associations," p. 49, maintains that the Association continues to be a forum for discussion. Obler, "Constitutional Crisis," pp. 384-386, thinks that this function has been lost.

[100]Daniel Katz and Robert L. Kahn, The Social Psychology of Organizations (New York, 1966), p. 87. "The American Medical Association, with its restriction of apprentices and its prestiged and privileged position in the body politic, is less open to outside influence than a political party constantly seeking the majority endorsement of a capricious public. Hence the American Medical Association will attempt to change society first and its own internal program second." Garceau, Political Life, p. 175, says, however, "The AMA owes to itself and to the public a better performance than it has recently received. It has lost a great deal of public confidence in matters of economic reform. It may some day lose public support in the decisions of malpractice. It has never fully convinced the public about the licensure of orthodox scientific medicine."

[101]Haro, "Overdue," pp. 461, 480.